Washington State Department of Health

COHORT PRESENTATION: PULMONARY AND EXTRAPULMONARY TB

Initials_____ **County**_____ **TIMS Case #**_____

A) If the case is a child less than 5 years of age
□ Yes, source identified[1]

B) If the case is HIV+
□ Yes, source identified

1a. _____year-old [male / female] born in _____ (Country). Arrived in the US _____(year). Class A, B1, B2 _____[yes, no].
b. Risk/social factors [medical conditions, substance abuse, homeless, employment, other _____]
c. _____ (date) patient presented with symptoms of [cough, hemoptysis, night sweats, fever, weight loss, chest pain, enlarged lymph node, other _____]
for _____ (days, weeks or months).
d. PPD ____mm read on _____ (date).
e. Chest x-ray shows [cavitary / abnormal non-cavitary / normal] taken on _____ (date).

2.a. This is a case of pulmonary[2] TB and/or extrapulmonary TB_____(site)
□ culture confirmed □ clinically confirmed □ provider diagnosed
b. Sputum[3] was collected on _____ (date) and received at lab on _____ (date).
c. MTD[4] negative/positive on _____ (date). □ not done
d. Sputum[5] smear [_____ plus positive / negative] reported on _____ (date). LHJ first notified_____ (date) by lab of sputum smear positive result.
e. Sputum culture [+ / - / not done] and reported on _____ (date). Sputum culture conversion [occurred / did not occur / not obtained] within 2 months of treatment.
f. Other specimens: source_____ collected on _____ (date).
Smear [_____ plus positive / negative] on _____ (date).
Culture results [+ , - , not done] and reported on _____ (date).
g. Sensitivity testing [pansensitive, MDR, resistant to_____]. LHJ first notified_____ (date) by lab of susceptibility results.
h. HIV[6] [positive / negative / refused / not offered] on _____(date).

3. TB treatment
a. Four-drug regimen or other regimen _____started on _____ (date).
b. Treatment plan of _____ (months).
c. On DOT? [yes / no] for a total of: □ 26 wks □ 9 mos □ 18 mos □ other_____
d. If no DOT, reason: □ lack of resources □ patient refused □ provider refused □ other_____
e. Pharmacy checks done[7]? [yes, no].
f. Completed _____ weeks of TB treatment on _____(date) **OR** still on therapy and is due to complete _____ (date).
g. Did not complete therapy because:
□ refused treatment
□ lost
□ died □TB related □non-TB related
□ moved Date of interjurisdictional referral:_____
□ reported at death
h. Treatment interruptions[8] □ yes □ no
Medical/adverse reactions □ yes □ no
Patient nonadherence □ yes □ no
Provider reasons □ yes □ no

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4. Follow-up of the case

a. Completion of therapy CXR on _____ (date) showed [improved / worsened / no change / not done]

b. If treatment still ongoing, follow-up CXR on _____ (date) showed [improved / worsened / no change / not done]

5. Contacts (*indicate number in each box*)

	Identified[9]		Started treatment for LTBI[15]
	Date contacts identified[10]_____		Completed treatment for LTBI
	Date contacts interviewed[11]_____		Currently on treatment
	Evaluated[12] [Include those with initial and F/U PPD CXR if PPD positive]		Discontinued treatment for LTBI due to:
	Date of evaluation[13] _____		Adverse reactions to medications
	Prior positive PPD		Died
	Infected (TST+) without disease [confirmed by x-ray]		Moved[16]
	Diagnosed with TB disease		Refused to continue treatment
	Eligible for treatment of latent TB infection[14]		Lost to follow-up
	Started window prophylaxis (i.e., for those < 5 yrs of age, immunocompromised)		Provider decision (e.g. unable to monitor pt care)

6. Items needing follow-up:_____

_____

Please fill out but do not present this information during cohort review

1. LHJ first notified_____ (date) by [health care provider, other_____]
2. DOH first notified by LHJ_____ (date) [includes DOH calling LHJ and start of report]

1. Be prepared to present the source case and associated contact investigation, including whether this child or HIV infected person was listed as a contact in the contact investigation for the source case.

2. A disease site in the respiratory system including the airways (e.g., endobronchial, laryngeal).

3. Report the first sputum collected. All lab questions refer to local labs **or** state Public Health Lab.

4. The Gen-Probe Amplified Mycobacterium Tuberculosis Direct Test (abbreviated as AMTD or MTD) is a technique used to detect and identify *MTB* complex directly from respiratory specimens.

5. Report initial sputum unless initial is smear negative. Then report first sputum that is smear positive.

6. HIV testing should be current and done within 6 months of diagnosis.

7. A review of pharmacy records to determine whether a patient filled their anti-tuberculosis medications.

8. Report >2 weeks interruption during initial phase or >20% during the continuation phase.

9. Contacts identified include all true contacts with legitimate names, addresses, and DOB.

10. Report date when the first contact was identified (usually when case was interviewed).

11. Report date when the first contact was interviewed.

12. Evaluation is defined as 1) TST positive, CXR completed, and sputum collected if indicated; 2) TST placed and read after the end of the window period; or 3) contacts with documentation of previous diagnosed disease or LTBI—even if no further tests and exams are done. If started on treatment for LTBI, do not include these contacts in the number of "eligible for treatment."

13. Report date when the first contact was evaluated with an initial PPD.

14. Contacts "eligible for treatment of latent TB infection" include: i) all TST+ contacts recommended for medical follow-up for whom treatment is medically indicated; and ii) persons identified during a contact investigation who need treatment, *whether or not they were TST tested* (e.g. HIV).

15. Report the number who started treatment for LTBI. Do not report the number of people who did ***not*** start treatment for LTBI; however, be prepared to explain. Do not report people who received window prophylactic treatment and were found not to have had latent TB infection. Provide updated information on those contacts who started treatment for LTBI.

16. Complete an interjurisdictional referral form. Send the form to the county where contact is transferring and send copy to DOH TB Program.